

MDR Tracking Number: M5-04-0273-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on September 19, 2003.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the functional capacity evaluation/ test and special reports were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service May 6, 2003 denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30th day of December 2003.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
GR/gr

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 21, 2003

Re: IRO Case # M5-04-0273-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ____ for an independent review. ____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ____ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ____ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ____ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured her right thumb in ____ when she slipped and landed on her right hand. She has been treated with physical therapy, chiropractic treatment, injections, work hardening, medication and surgery on the right thumb.

Requested Service(s)

Functional capacity evaluation and special reports 5/6/03

Decision

I agree with the carrier's decision to deny the requested test and report.

Rational

The patient received extensive conservative treatment, injections and surgery for a diagnosed tenosynovites. Eleven months of treatment and work hardening was not of benefit to the patient, and surgery also failed to relieve symptoms.

A report of 12/20/02 stated a determination that the patient had a preexisting degenerative arthritis of the first metacarpal joint at the base of the thumb that was aggravated by the fall.

Based on the documentation presented for this review, the patient had a preexisting arthritic condition with a superimposed sprain/strain of the first metacarpal joint, and should have responded with conservative treatment within six to eight weeks.

Treatment that was not appropriate and over utilized contributed to the chronicity of the symptoms.

The documentation presented does not indicate that the actual problem was addressed. From the records provided, it appears that the patient's condition plateaued in a diminished condition many months prior to 5/6/03. The patient was placed at MMI on 1/23/02, and the treatment, including the FCE was unnecessary and unreasonable after that date.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.